

# Exhibit P

## *Additional Medical Records*



# Bellevue

BELLEVUE HOSPITAL  
CENTER  
462 1st Ave  
New York NY 10016

Patient: Rodriguez, Peter  
MRN: 4443620, DOB: [REDACTED], Sex: M  
Acct #: 202076405  
Admit: 8/3/2020, IP: 8/4/2020, Discharge: 8/5/2020

Support Systems Parent;Spouse/significant other - AF  
Assistance Needed none -AF  
Type of Residence Other (Comment) -AF  
Patient expects to be discharged to: DOC -AF

## Unit Orientation - Tue August 04, 2020

Row Name	1300	1200
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### Unit Orientation

Precautions	None;Fall risk - AF	Fall risk -AF
Familiar with Unit	Yes -AF	—
Side Rails/Bed Safety	2/4 -AF	2/4 -AF
Bed Wheels Locked	Yes -AF	Yes -AF
Bed In Lowest Position	Yes -AF	Yes -AF
NonSkid Footwear	On -AF	On -AF
Family/Significant Other Notification	Police custody/DOC -AF	—

Row Name	1300	1200
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### Orientation to the Unit

Arm Bands On	—	ID;Fall -AF
Call Light Within Reach	Yes -AF	Yes -AF

## Vitals - Tue August 04, 2020

Row Name	1600	0900	0700	0243
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### Screening Vitals

BP	117/80 -DT	119/76 -JC	133/83 -YY	108/57 -SP	
Pulse	81 -DT	77 -JC	79 -YY	86 -SP	
Resp	18 -DT	18 -JC	18 -YY	15 -SP	
Row Name	2200	1600	0900	0700	0243

### Vital Signs

Restart Vitals Timer	—	—	—	—	Yes -SP
Temp	98 °F (36.7 °C) - CS	97.9 °F (36.6 °C) -DT	97.6 °F (36.4 °C) -JC	97.3 °F (36.3 °C) -YY	98.2 °F (36.8 °C) -SP
Temp src	—	Oral -DT	Oral -JC	Oral -YY	Oral -SP
BP Location	—	Left arm -DT	Left arm -JC	Right arm -YY	Right arm -SP
Patient Position	—	Lying -DT	Lying -JC	Lying -YY	Lying -SP
Row Name	2351	1200			

### Vitals

Cardiac Rhythm	Normal sinus rhythm -CS	Normal sinus rhythm -AF
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Ectopy	—	Premature ventricular contractions -AF			
Ectopy Frequency	—	Occasional -AF			
Row Name	0700				
Measurements					
BSA DuBois (Calculated - sq m)	2.53 sq meters - YY				
Row Name	1600	0900	0700	0243	
Oxygen					
SpO2	98 % -DT	99 % -JC	97 % -YY	98 % -SP	
O2 Device	—	—	—	None (Room air) -SP	
Row Name	0700				
Measurements					
Height	1.829 m (6') -YY				
Weight	136 kg (298 lb 15.1 oz) -YY				
BMI (Calculated)	40.5 -YY				
Row Name	0700				
Height and Weight					
Weight in (lb) to have BMI = 25	183.9 -YY				
Row Name	2348	2240	1000	0430	0040
Pain Assessment					
Pain Assessment	No/denies pain - CS	No/denies pain - CS	No/denies pain - AF	—	0-10 -CB
Pain Score	0 -CS	0 -CS	0 -AF	0 -CB	1 -CB
Row Name	1200				
Sepsis Screening					
Is there a suspected or current infection?	No -AF				
Does the patient have altered mental status from last assessment?	No -AF				
Suspected/ Known Immunocompromise	No -AF				
Provider notified	na -AF				
Row Name	0700				
Height and Weight					
% Weight Change Since Birth	0 -YY				
BSA (Calculated - sq m)	2.62 sq meters - YY				



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Acct #: 202775506  
Admit: 12/6/2020, IP: 12/6/2020, Discharge:  
12/7/2020

## ED Notes (continued)

ED Attending Note by B [REDACTED] Klass, MD at 12/06/20 2013 (continued)

- Admission order placed? **Yes**
- Legal status order placed? **Yes**
- Observation order placed? **Yes**
- Standing psychiatric medications ordered? **No**
- Non-psychiatric medications ordered if appropriate (e.g., recommendations from medical moonlighter)? **N/A**

### OBSERVATION STATUS

- Level of observation on the inpatient unit: **1:1**
- Has 1:1 or continuous observation been ordered (if clinically appropriate)? **Yes**

### MED RECONCILIATION

- "Order Sign & Hold" admission med rec completed at time of update? **Yes**

Electronically Signed by B [REDACTED] Klass, MD on 12/06/20 2013

## Discharge Summary - Encounter Notes

Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606

Author: A [REDACTED] Junewicz, MD

Service: Adolescent Psych

Author Type: Physician

Filed: 12/07/20 1606

Creation Time: 12/07/20 1316

Status: Signed

Editor: A [REDACTED] Junewicz, MD (Physician)

### Inpatient Psychiatry Discharge Summary

Name: Peter Rodriguez

MRN: 4443620

DOB: [REDACTED]

Admission Date: 12/6/2020

Discharge Date: 12/7/2020

**Chief Complaint:** "All I wanted was a pin number - that should not have taken half an hour!"

#### Brief HPI:

Peter Rodriguez is a 30 year old man, currently in DOC custody for alleged murder, with past diagnoses of intermittent explosive disorder, borderline personality disorder, antisocial personality disorder, substance use, history of psychiatric hospitalizations and concerns for self-injury and suicide attempts (last at Bellevue in



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## Discharge Summary - Encounter Notes (continued)

### Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

2/2018 due to concerns for attempted hanging at Rikers, which the patient states he "faked"), who presented as DOC referral for escalating behavioral impulsivity and behavioral dysregulation.

Per his referral and review of recent Rikers records, the patient has past diagnoses of intermittent explosive disorder and borderline personality disorder. He had been followed by mental health at Rikers and was treated with Remeron until July 2019, when the medication was discontinued because he was reportedly "hoarding" the medication. He has recently been followed with therapy visits only, and he has not recently been prescribed psychotropic medication. Prior to his referral, he was being housed in an enhanced restraint housing area, and was involved in a use of force with the DOC. He was complaining that the DOC were neglectful towards him and expressing frustrations about this. Per his referral form, he commented that he is "looking at 25 years soon" and expressed conditional SI stating, "if this what it will be like I'd rather not live." He was pacing in his cell, dysregulated and impulsive, and he "placed his sweatshirt around a pipe undecisive on how to injure self and others." However, the referral notes that the patient is "well-known" to the DOC for similar behaviors. Prior to his arrival at the hospital, the captain and several officers were able to de-escalate him "to a calmer space where he was able to sit on a bench and practice deep breathing."

Per his evaluation in the Bellevue CFES (2/6/2020):

"Upon evaluation of the patient, he was calm, cooperative, able to engage, demonstrating dysphoric, tearful affect. He continued to repeat that "there's nothing left for me" and that he only wants to "end it all". He said that he recently attempted to hang himself but the guards caught him. He said he is hoping to find some way in which to block vision of his cell so he can complete suicide. He said he has been hoarding Aspirin in his cell. He said he started refusing Remeron due to weight gain, and had been hoarding that medication as well. He continued to describe how he feels like a burden to his mother and feels as if it would be better if he were dead. He endorsed poor sleep and appetite over the last few weeks. He denied any AH or paranoid thoughts.

His mother [REDACTED] ([REDACTED]) was called without answer.

The patient was admitted to 19W on 9.39 status. After his arrival to 19W, the patient refused to allow the DOC to search him and remove his sneakers, and then became combative with the DOC, who used force. He was agitated and threatening, a CMT was called, and he received emergency IM medication and was placed in restraints.

On the morning of 12/7/2020, the patient approached the RN station, began making threats to harm staff, and started demanding to use the phone. A CMT was called. However, when the CMT team arrived and approached the patient, he was calmly engaging a phone call. He ended the call in order to participate in an interview with me and several unit staff. He calmly explained that he had been feeling frustrated at the DOC because he had wanted to make phone calls, but the DOC had taken given him incorrect pin numbers, and had taken too long to give him a correct pin number ("all I wanted was a pin number - that should not have taken half an hour!"). We discussed appropriate ways to voice frustration and maintain appropriate behavior on the unit. The patient said that he said that he would be able to cooperate with unit rules and follow all staff directions. While PRN medications were considered and offered (given his initial level of agitation), he was able to de-escalate without medications or further interventions.

The patient subsequently maintained calm, cooperate behavior on the unit, following all staff directions. While he continued to advocate for his needs, he did so in a calm, appropriate, nonthreatening manner. He requested to be discharged from the hospital, and then participated in an interview regarding the reasons for his hospital presentation. He explained that prior to his referral, he had conflicts with the DOC about his



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## Discharge Summary - Encounter Notes (continued)

### Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

housing. This led him to remain in his cell, "splash" DOC officers, and engage in other behaviors to provoke them, such as placing a shirt on a pipe and threatening to hang himself. He stated that he engaged in these behaviors because he feels that DOC hasn't been meeting his needs, and would like for this to change.

He denied any current or recent psychiatric symptoms or complaints. He denied SI, HI, depression, anxiety, sleep problems, appetite problems, AVH, or hopelessness. He denied recent substance use. He denied any history of manic episodes or psychosis. He said that he does not think he needs to be a psychiatric hospital at this time, he does not want medications or any psychiatric treatment in the hospital, and wants to be discharged.

Asked about his recent reports of suicidality, he again focused on his frustrations with the DOC. He repeatedly denied any recent genuine suicidality, and he denied any problems to which suicide would be the answer. He said that if he were to develop SI, feelings of depression, or other psychiatric symptoms, he would promptly notify staff and seek mental health treatment. He also engaged in safety planning, identifying triggers, coping skills, friends/family he can call, and other supports.

Patient had provided his mother as collateral, but she was unable to be reached. He provided me with the phone number for his uncle, [REDACTED], and consent to speak with him about his care. Mr. [REDACTED] reported that he speaks with the patient often, and last spoke with him a few days ago. He said that the patient has been "completely fine" and has not described recent stressors or shown other evidence of distress. To his knowledge, the patient has no history of mental health problems or needs, and he has no such concerns regarding such issues in the patient at present.

### Past Psychiatric History:

- Prior diagnoses: Intermittent explosive disorder, borderline personality disorder, antisocial personality disorder
- Hospitalizations: Multiple, last in 2/2018 at Bellevue per Quadramed records; multiple hospitalizations as a child by his foster parents
- Outpatient treatment: Patient has been followed by mental health at Rikers, recently with therapy visits.
- Medication trials: The patient explained that he had been treated with Remeron in the past, but did not think this medication had been helpful. (He is not currently prescribed medications at Rikers.)
- Suicide attempts/Self-harm: Per chart, patient has reported a history of past attempts, including intentional overdose on aspirin and alcohol, and hanging attempts at Rikers. However, on my interview with the patient, he said that he had "faked" suicide once in the past in 2018, in the context of frustrations with the DOC and his housing. He denied any history of genuine suicide attempts or behaviors.
- Violence: Notable for alleged murder, as well as in-hospital violence
- Trauma/Abuse: Patient endorsed a history of traumatic experiences, but declined to discuss this further.

**Past Medical History:** History includes asthma, recently treated with Advair 100/50mg BID

**Family History:** Per Bellevue and Rikers records, family history is notable for schizophrenia and suicide

**Social History:** Per patient and chart, he has a history of foster care and resided in multiple foster homes (~30).

**Substance Abuse History:** Per Bellevue records, patient has a history of polysubstance use, including cocaine and opiate use. He denies recent substance use.



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## Discharge Summary - Encounter Notes (continued)

Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

### Hospital Course:

The patient was admitted to 19W on 9.39 status.

Please see HPI above for his evaluation and course on 19W on 12/6/2020 and 12/7/2020.

Briefly, the patient's course was notable for demanding, threatening behaviors, which he exhibited in order to have his needs met (i.e. for phone calls, etc.), and in the context of conflicts with the DOC. He was maintained on 2:1 monitoring due to concerns about these behaviors in the context of his history of aggressive/violent behaviors. While he received PRN medications and restraints for these behaviors on 12/6/2020, he exhibited an ability to de-escalate without the use of medications or other interventions on 12/7/2020. On evaluation, he denied any did not exhibit acute mood or psychotic symptoms or other evidence of an acute psychiatric illness (see formulation below for full details of the assessment). He said that he did not want medications or other treatment in the hospital, and requested to be discharged. He did not meet criteria or involuntary treatment with medications or further hospitalization against his wishes. Therefore, no psychotropic medications were prescribed, and it was determined that he would be discharged.

### Medications:

#### Long Acting Injectable Administration (last 720 hours)

None

### Pertinent Medical Events:

Patient was evaluated by medicine on 12/6/2020, after the altercation with DOC staff and CMt intervention on 12/6/2020. He complained of pain on his wrists/ankles where cuffs were placed, also shoulder pain and low back pain. He was evaluated by medicine consult, who recommended X-rays of L and R wrist, L and R ankle, L and R shoulders, and L spine, and PRN pain management with ibuprofen.

On 12/7/2020, it was determined that the patient did not require treatment in a psychiatric hospital (see above). He was re-evaluated by medicine consult regarding the above recommendations. Medicine consult confirmed that he did not have any acute injuries that required immediate treatment in a hospital setting. His x-rays were nonurgent, and may be deferred for completion after discharge (did not require that he remain the hospital), and could be reconsidered if his symptoms persist for more than 5-7 days (or sooner if patient develops swelling, neurologic deficits, or inability to bear weight). In interim, his pain could continue to be managed with PRN pain relief (acetaminophen 1000 mg q8h PRN or ibuprofen 4-600 mg q8h PRN for pain).

### Pertinent Labs:

CBC:

#### Lab Results

Component	Value	Date
WBC	10.77	12/06/2020
RBC	5.82	12/06/2020
HGB	17.2	12/06/2020
HCT	50.1	12/06/2020
MCV	86.1	12/06/2020
MCH	29.6	12/06/2020
MCHC	34.3	12/06/2020



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## Discharge Summary - Encounter Notes (continued)

### Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

MPV	10.9	12/06/2020
RDW	12.5	12/06/2020
RDW-SD	41.6	02/06/2018
NEUTROPHIL %	69.7	12/06/2020
NEUTROPHIL ABS	7.51	12/06/2020
LYMPH %	22.0	12/06/2020
LYMPH ABS	2.37	12/06/2020
MONOCYTE %	7.7	12/06/2020
MONOCYTE ABS	0.83	12/06/2020
EOSINOPHIL %	0.1 (L)	12/06/2020
EOSINOPHIL ABS	0.01 (L)	12/06/2020
BASOPHIL %	0.3	12/06/2020
BASOPHIL ABS	0.03	12/06/2020

### BMP:

#### Lab Results

Component	Value	Date
SODIUM	141	12/06/2020
SODIUMVEN	141	09/15/2017
POTASSIUM	4.1	12/06/2020
POTASSIUMVEN	3.9	09/15/2017
CHLORIDE	107 (H)	12/06/2020
CHLORIDEVEN	107	09/15/2017
CO2	22 (L)	12/06/2020
BUN	11	12/06/2020
CREATININE	0.9	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020
LIPEMIA	Not Detected	12/06/2020
LIPEMIA	Not Detected	12/06/2020

### CMP:

#### Lab Results

Component	Value	Date
BUN	11	12/06/2020
SODIUM	141	12/06/2020
SODIUMVEN	141	09/15/2017
POTASSIUM	4.1	12/06/2020
POTASSIUMVEN	3.9	09/15/2017
CHLORIDE	107 (H)	12/06/2020
CHLORIDEVEN	107	09/15/2017
CO2	22 (L)	12/06/2020
CREATININE	0.9	12/06/2020
TOTALPROTEIN	7.5	12/06/2020
ALBUMIN	5.0	12/06/2020


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**Discharge Summary - Encounter Notes (continued)**
**Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)**

TOTALBILIRUBIN	0.8	12/06/2020
ALKPPOS	107 (H)	12/06/2020
ASTSGOT	37	12/06/2020
ALTSGPT	38 (H)	12/06/2020
LIPEMIA	Not Detected	12/06/2020
LIPEMIA	Not Detected	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020

**Hepatic Profile:**
**Lab Results**

Component	Value	Date
ALBUMIN	5.0	12/06/2020
TOTALPROTEIN	7.5	12/06/2020
TOTALBILIRUBIN	0.8	12/06/2020
DIRECTBILIRUBIN	0.2	08/05/2020
ALKPPOS	107 (H)	12/06/2020
ALTSGPT	38 (H)	12/06/2020
ASTSGOT	37	12/06/2020
LIPEMIA	Not Detected	12/06/2020
LIPEMIA	Not Detected	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
HEMOLYSIS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020
ICTERUS	Not Detected	12/06/2020

**TSH**
**Lab Results**

Component	Value	Date
TSH	0.817	12/06/2020

**Folate**
**Urine Tox:**
**Metabolic Screening:**

 Body mass index is 37.97 kg/m<sup>2</sup>.

Blood Pressure: (Patitent's safety)

**Pertinent Imaging/Studies:** None completed - see medical course above

**Formulation:**

Peter Rodriguez is a 30 year old man, currently in DOC custody for alleged murder, with past diagnoses of intermittent explosive disorder, borderline personality disorder, antisocial personality disorder, substance use, history of psychiatric hospitalizations and concerns for self-injury and suicide attempts (last at Bellevue in 2/2018 due to concerns for attempted hanging at Rikers, which the patient states he "faked"), who presented



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## Discharge Summary - Encounter Notes (continued)

Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

as DOC referral for escalating behavioral impulsivity and behavioral dysregulation.

The patient's current presentation is most consistent with an Adjustment Disorder with disturbance of conduct and emotions. His recent reports of SI and dysregulated behaviors have occurred within the context of frustrations with the DOC, and likely reflect manipulative efforts to have his needs met. Given his past diagnoses of borderline and antisocial personality disorders, it is likely that personality traits are playing a strong role. On evaluation, he is logical, organized, calm and appropriate, and is able to advocate for his needs. He denies and does not exhibit suicidality, neurovegetative symptoms, or other acute mood or psychotic symptoms, or other evidence of acute psychiatric illness. Collateral (from his uncle, see above) and review of Rikers records confirms this (with neither source indicating suicidality, depression, or other acute psychiatric issues prior to his conflict with the DOC on 12/6/2020). Regarding his recent threatening and agitated behaviors, he exhibits an ability to de-escalate, achieve and maintain calm, cooperative, appropriate behavior without the use of psychiatric medications or interventions. He does not want medications or other treatment in the hospital, he is requesting discharge, and he does not meet criteria or involuntary treatment with medications or further hospitalization against his wishes.

### Discharge Diagnosis:

Adjustment Disorder with disturbance of conduct and emotions  
Unspecified Personality Disorder

### Suicide Risk Assessment:

Regarding this patient's risk for suicide, static/unmalleable risk factors include his history of prior concerns for self-injury and suicide attempts (however, patient states these were "faked"), substance use, trauma, family history of psychiatric illness and suicide, and personality trait vulnerabilities leading to impulsivity and poor coping skills. Mitigating factors include his access with willingness to utilize social supports, ability to identify coping skills, access to appropriate supervision and support, future-orientation, restricted access to firearms, restricted access to potentially lethal medications and restricted access to disinhibiting substances. On referral to the hospital, he expressed suicidality and evidenced behavioral dysregulation in the context of conflicts with the DOC. On re-evaluation on 19W, the patient's mental status is reassuring. At the time of assessment, there is no SI, depression, manic/hypomanic/mixed state, severe anxiety, irritability, psychosis, hopelessness, egodystonic impulsivity, aggressiveness, agitation, disruptive behavior, intoxication, access to firearms and access to potentially lethal medications. He/she is able to actively engage in safety planning and identify coping skills and appropriate supports.

While this patient's risk for suicide is chronically elevated, there are no acute risk factors that would be mitigated by or require further treatment in a hospital setting at this time.

### Violence Risk Assessment:

Regarding this patient's risk for violent/aggressive behavior, static/unmalleable risk factors include his history of trauma, incarceration, personality trait vulnerabilities leading to impulsivity, violent behavior and using aggression to solve social problems. While the patient has exhibited threatening, agitated behaviors, he currently exhibits an ability to de-escalate and refrain from aggression or agitation. On evaluation on 19W, this patient's mental status is reassuring. At the time of assessment, there is no evidence of impulsivity, substance use difficulties and high emotional distress. He is able to calmly discuss his/her emotions, identify triggers for anger/aggressive behaviors, identify coping skills to manage anger and stress and respond to verbal redirection.



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## Discharge Summary - Encounter Notes (continued)

### Discharge Summary by A [REDACTED] Junewicz, MD at 12/07/20 1606 (continued)

While this patient's risk for violent behavior is chronically elevated, there are no acute risk factors that would be mitigated by or require further treatment in a hospital setting at this time.

In light of this, the patient may be safely maintained with an outpatient level of care as outlined in the plan below. Further, at this time, suicide in the foreseeable future is neither likely nor predictable, and inpatient care or further observation in a hospital setting will not reduce the patient's risk of suicide significantly to justify its restrictions.

### Discharge Plan:

- Discharge to DOC custody
- Patient is not currently prescribed psychotropic medication
- He should continue to follow with mental health treatment for therapy, on-going assessment, and consideration of medications as appropriate while in DOC custody
- Patient should receive X-rays of L and R wrist, L and R ankle, L and R shoulders, and L spine (see above)
- Continue pain management with PRN pain relief (acetaminophen 1000 mg q8h PRN or ibuprofen 4-600 mg q8h PRN for pain)
- Continue current medications for asthma (Advair) and other medical conditions as prescribed (no changes were made during this hospital encounter)

A [REDACTED] Junewicz, MD

Electronically Signed by Alexandra Junewicz, MD on 12/07/20 1606

### Discharge Summary by B [REDACTED] Izuka, RN at 12/07/20 2001

Author: B [REDACTED] Izuka, RN

Service: —

Author Type: Registered Nurse

Filed: 12/07/20 2001

Creation Time: 12/07/20 1949

Status: Signed

Editor: B [REDACTED] Izuka, RN (Registered Nurse)

## RN DISCHARGE NOTE

Peter Rodriguez  
30 y.o.  
male  
MRN: 4443620

Patient discharged out of the unit to Department of Corrections (DOC) custody going to Manhattan Detention Center at 7:37 PM via ambulatory. Patient was escorted out of the unit by Captain Flemming with two other DOC officers.

Discharge instructions and After Visit Summary reviewed. Patient verbalized understanding.

B [REDACTED] Izuka

NYC  
HEALTH+  
HOSPITALS

Bellevue

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**Discharge Summary - Encounter Notes (continued)**

**Discharge Summary by B [REDACTED] Izuka, RN at 12/07/20 2001 (continued)**  
12/7/2020

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Electronically Signed by B [REDACTED] Izuka, RN on 12/07/20 2001



# Correctional Health Services

**Patient Name:**  
PETER RODRIGUEZ  
**NYSID:**  
09839298P

**Latest Book and Case#:**  
3491603090  
**Patient Facility:**  
NIC

## MED - Sick Call Visit

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**  
Book & Case #: **3491603090** NYSID: **09839298P**  
Facility: **NIC** Housing Area: **2C**

## Subjective

Chief Complaint/Reason for Visit: **Pt was standing on tier attempting to negotiate with DOC staff to bring him to clinic.**

History of Present Illness: **Inmate stated that due to fire last night and smoke filled cell he is having difficulty breathing. He was blocking the tier and not allowing staff to walk down the tier. Pt was insisting on being brought to clinic. I evaluated patient on the tier**

## Vital Signs History (previous visits review)

Last time vitals taken prior to this visit: **07/20/2021**

BP: **145/91 (07/20/2021 1:18:12 AM)**

Pulse: **88 (07/20/2021 1:18:12 AM)**

Pulse Rhythm: **Regular (07/20/2021 1:18:12 AM)**

RR: **16 (07/20/2021 1:18:12 AM)**

Resp Quality: **Regular (07/20/2021 1:18:12 AM)**

O2 Sat: **98 (07/20/2021 1:18:12 AM)**

T: **97.1 (07/20/2021 1:18:12 AM)**

## Open Orders: TPR [MHMIGRATION]

TPR and MH Clinicians Progress Note [MHMIGRATION]

Referral - Bellevue, Dermatology [BELLEDERM]

On-Site Specialty Follow-Up - Neurology [NEUROORDER]

MH Order - Targeted Evaluation of Self-Destructive Behavior [TARGETEVAL]

COVID19 PCR – Anterior Nares [RP1]

CDU Transfers [INTCDU]

Referral - Orthopedic [ORTHO]

On-Site Specialty Follow-Up - Podiatry [PODIAORDER]

Referral - Bellevue, Neurology [BELLENEURO]

Urinalysis, Routine [0159-4]

Hemoglobin A1c (GlycoHgb) [0102-4]

Basic Metabolic Profile (BMP) [2555-1]

COVID19 PCR – Anterior Nares [RP1]

Referral - Dental [DENTAL]

COVID19 PCR – Anterior Nares [RP1]

Glucose, Fasting [0095-0]

Hemoglobin A1c (GlycoHgb) [0102-4]

Thyroid PNL-T3U,T4,TSH [0007-5]

MH Order - TPR and MH Clinician's Progress Note [TPR]

COVID19 PCR – Anterior Nares [RP1]

## INT - Step 1 - Vitals

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

NIC

Book & Case #: **3491603090** NYSID: **09839298P**  
Facility: **NIC** Housing Area: **2C**

Last height (inches): **72 (03/26/2021 3:14:50 PM)** Last Weight: **280 (03/26/2021 3:14:50 PM)**

Temperature: **97.7** FbaF

Temperature site: **Temporal**

Pulse rate: **80** RR: **16** Respiration Type: **Unlabored**

Pulse Ox: **100%** Room Air: **Yes**

## **MED - Physical Examination**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **NIC** Housing Area: **2C**

General

**General Appearance:** No Acute Distress

Respiratory

**Respiratory Effort:** No respiratory distress

**Auscultation:** Clear to auscultation bilaterally

**Respiratory Notes:** Pt speaking loudly, quickly and in full sentences.

No use of accessory muscles or nasal flaring noted.

Cardiovascular

**Auscultation:** RRR, Normal S1 + S2

Musculoskeletal

**Gait & Station:** Normal

## **MED - Assessment & Plan**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **NIC** Housing Area: **2C**

### **Allergy Review**

**\* CARROT (Critical)**

**FISH DERIVED (FLAVORING AGENT) (Critical)**

**Clindamycin (CLINDAMYCIN HCL CAPS) (Moderate)**

**Poultry (Moderate)**

**fish derived (Moderate)**

**lactose (Moderate)**

Allergies reviewed:

**YES**

### **Assessment:**

#### **Problem # 1:**

Smoke inhalation - STABLE (ICD-508.2) (ICD10-J70.5)

Pt claims SOB since smoke inhalation last evening, yet he was not carrying his inhaler and was in no acute distress on examination. Lungs clear and POx=100%.

Once patient was informed that he is not going to clinic at this time, he stated "I am making a Confidential



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

NIC

Allegation."

Injury report requested from DOC and patient will be brought to clinic on the next tour to obtain further information regarding this allegation.

**Summary:**

Signed By: Choleff, L [REDACTED] at 7/20/2021 12:36:41 PM



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

NIC

## MED - On-Site Specialty

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **NIC** Housing Area: **2C**

Select Specialty: **Optometry**

Chief Complaint/Reason for Visit: **DV Blur FB sens 2/2 fire in housing unit lost EG LEE x 6y NMEH FEH DM**

## Vital Signs History (previous visits review)

Last time vitals taken prior to this visit: **04/09/2021**

BP: **140/87 (04/09/2021 9:47:42 PM)**

Pulse: **85 (04/09/2021 9:47:42 PM)**

Pulse Rhythm: **Regular (04/09/2021 9:47:42 PM)**

RR: **16 (04/09/2021 9:47:42 PM)**

Resp Quality: **Regular (04/09/2021 9:47:42 PM)**

O2 Sat: **99 (04/09/2021 9:47:42 PM)**

T: **98.3 (04/09/2021 9:47:42 PM)**

## MED - Physical Examination

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **NIC** Housing Area: **2C**

Chart Reviewed

1. Specialty Clinic opto

Examination:

Right Eye:

VAsc 20/40 j1

Pupils: PERRLA -APD

Adnexae: Normal.EOMI Motil: FSE

Lids and Lashes: WNL

Conjunctiva: white and quiet.

Cornea: Clear.

Anterior Chamber: Deep and Quiet.

Iris: flat.

Lens: clear.

Vitreous: Clear.

IOP: 16 mmhg.

Subj.Refraction: -025-050x180 20/20 j1

Fundi C/D 0.3 A/V 2/3 + Foveal reflex.

Left Eye:

VAsc 20/40 j1



# Correctional Health Services

**Patient Name:**  
PETER RODRIGUEZ  
**NYSID:**  
09839298P

**Latest Book and Case#:**  
3491603090  
**Patient Facility:**  
NIC

Pupils: PERRLA -APD.  
Adnexae: Normal EOMI Motil: FSE  
Lids and Lashes: WNL  
Conjunctiva: white and quiet.  
Cornea: clear.  
Anterior Chamber: Deep and quiet.  
Iris: flat.  
Lens: clear.  
Vitreous: clear.  
IOP: 16 mmhg.  
Subj.Refractation: pl-050x180 20/20 j1  
Fundi C/D 0.3 A/V 2/3 + Foveal reflex.

## MED - Assessment & Plan

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**  
Book & Case #: **3491603090** NYSID: **09839298P**  
Facility: **NIC** Housing Area: **2C**

### Allergy Review

\* **CARROT (Critical)**  
**FISH DERIVED (FLAVORING AGENT) (Critical)**  
**Clindamycin (CLINDAMYCIN HCL CAPS) (Moderate)**  
**Poultry (Moderate)**  
**fish derived (Moderate)**  
**lactose (Moderate)**

Allergies reviewed:  
**YES**

Specialty:  
**Optometry**

### Assessment:

#### **Problem # 1:**

Astigmatism - bilateral (ICD-367.20) (ICD10-H52.203) - New Problem

**Bullet Assessment:** Comment Only

DV EG ordered

#### Summary:

**Added new problem of Astigmatism, bilateral (ICD-367.20) (ICD10-H52.203)**

**Assessed Astigmatism, bilateral as new**

## **ALL - Disposition**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**  
Book & Case #: **3491603090** NYSID: **09839298P**  
Facility: **NIC** Housing Area: **2C**



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

NIC

**Disposition**

Selected disposition: **General Population**

Signed By: Scholnick, B [REDACTED] at 4/13/2021 11:43:09 AM

Correctional Health Services  
55 Water Street 18th Fl  
New York, NY 10041

2/1/2022

Order Form

## REFERRAL ORDER

<b>Authorizing Provider:</b>	R ■ Hai MD	<b>Service Provider:</b>	CHS
<b>Auth Provider NPI:</b>	1447660352		
<b>Signing Provider:</b>	R ■ Hai MD		
<b>Phone:</b>		<b>Phone:</b>	
<b>Fax:</b>		<b>Fax:</b>	
<b>Patient Name:</b>	PETER RODRIGUEZ	<b>DOB:</b>	■ ■ ■ ■ ■ ■ ■ ■ ■ ■
<b>Home Phone:</b>		<b>Sex:</b>	Male
<b>Work Phone:</b>		<b>SSN:</b>	
<b>Resp. Provider:</b>		<b>Cell Phone:</b>	
		<b>Age:</b>	31
		<b>Patient ID:</b>	23447
<b>Primary Ins:</b>		<b>Secondary Ins:</b>	
<b>Group:</b>		<b>Group:</b>	
<b>Policy:</b>		<b>Policy:</b>	
<b>Insured ID:</b>		<b>Insured ID:</b>	

<b>Code</b>	<b>Description</b>	<b>Diagnoses</b>
OPTO	Referral - Optometry	VISION CHANGES (ICD-H53.9)
<b>Order Number:</b>	707050-1	<b>Quantity:</b> 1
<b>Authorization #:</b>		<b>Priority:</b>
<b>Start Date:</b>	04/13/2021	<b>End Date:</b> 06/12/2040
<b>Electronically signed by:</b>	R ■ Hai MD	<b>Signed on:</b> 11/10/2020 10:49:19 AM
<b>Instructions:</b>	reports L. eye blurry vision x 2 weeks	



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

## MH - Psychiatry - Medication Reevaluation

**Patient:**

PETER RODRIGUEZ

**DOB:**

[REDACTED]

**Age:**

30 Years Old

**Book & Case #:**

3491603090

**NYSID:**

09839298P

**Facility:**

MDC

**Housing Area:**

RR

## Type of Visit

Type of Visit: Cellside Encounter

## Subjective

**Subjective (include general summary of functioning since last psychiatric provider note. This includes relevant clinical events, review of symptoms related to diagnosis patient is being treated for, and any recent self-injury or violence):** Patient was transferred from MDC on suicide watch after he was found in his cell with a sheet around his neck. He was seen by medical and was sent to the hospital for further evaluation. He states, "I don't why they sent me here." Reports that he tied sheet around his neck as a stunt which happened two days ago. However per chart review, he was sent to the hospital for evaluation because he was unresponsive and with blood around his facial area which they could not find the source. A goodbye letter was found as well, leaving everything to his two sons. Shared that he got a bad phone call and was having a bad day, but is doing better now. currently denies si/hi/a/vh

## Medication Compliance

**List every psychiatric medication being prescribed and percent compliance since last Psychiatric Provider visit:** BUSPIRONE HCL 10 MG TABLET BID 10mg TWICE A DAY 12/08/2020 12/22/2020 16/24 = 67% NON-CARRY Active ORAL 12/20/2020 9:00:00 AM 12/20/2020 9:00:00 PM MIRTAPAZINE 15 MG TABLET HS 15mg AT BEDTIME 12/08/2020 12/22/2020 8/12 = 67%

## Medication Side Effect

Medication Side Effect: No

## Mental Status

**Orientation:** Fully oriented

**Appearance:** Chronological Age, Normal Weight

**Behavior:** Cooperative, Good Eye Contact

**Activity:** No Abnormal Movements

**Speech:** Normal Rate

**Language:** No abnormalities observed



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

**Concentration:** Adequate

**Affect:** Appropriate

**Impulse control:** Adequate

**Thought process:** Spontaneous, Organized, Blocking

**Thought content:** No Abnormalities Observed

**Perceptual disturbance:** No Perceptual Distortions

**Memory** No Memory Impairment

**Suicidal:** Recent Gesture

**Homicidal:** No Homicidal Thoughts

**Judgement:** Adequate

**Insight:** Aware Accepts Treatment

## Vital Signs and Lab Results Flowsheet

### Change in Medication

Change in medication regimen: No

### Patient Education - Side Effects

Patient education provided on side effects of proposed medication: Yes

### Clinical / Risk Formulation and Plan

**Formulation (include identifying information, diagnosis and relevant history, general elements of treatment plan, status of current symptoms related to diagnosis, and if any acute issues related to risk of harm to self/others) (1st 2000 Char):** Patient was transferred from MDC on suicide watch after he was found in his cell with a sheet around his neck. He was seen by medical and was sent to the hospital for further evaluation. He states, "I don't why they sent me here." Reports that he tied sheet around his neck as a stunt which happened two days ago. However per chart review, he was sent to the hospital for evaluation because he was unresponsive and with blood around his facial area which they could not find the source. A goodbye letter was found as well, leaving everything to his two sons. Shared that he got a bad phone call and was having a bad day, but is doing better now. currently denies si/hi/a/vh.

Based on patient recent self-harm gesture he will be admitted to C-71 on suicide watch as a precautionary measure

**Diagnoses at this visit:** Borderline personality disorder

Adjustment disorder with disturbance of conduct (ICD-309.3) (ICD10-F43.24)

**Current Medications:**

MIRTAZAPINE 15 MG (REMERON 15 MG) (MIRTAZAPINE) 15 mg by mouth qhs Route: ORAL

BUSPIRONE HCL 10 MG (BUSPAR 10 MG) (BUSPIRONE HCL) 10 mg by mouth bid Route: ORAL

**Plan:** Admit to C-71 on SW

continue medication

**New Orders:**

MH Order - Psychiatry Medication Reevaluation [PSYCHMEDEVAL]

### Disposition/Level of Care

**Disposition/Level of Care?** C-71 Admission to Suicide Watch



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

## ALL - Disposition

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **RR**

## **Disposition**

Selected disposition: **C-71 Admission to Suicide Watch**

Signed By: Brooks, D [REDACTED] at 12/20/2020 7:50:59 PM



# Correctional Health Services

**Patient Name:**  
PETER RODRIGUEZ  
**NYSID:**  
09839298P

**Latest Book and Case#:**  
3491603090  
**Patient Facility:**  
MDC

## MED - Sick Call Visit

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **30 Years Old**  
Book & Case #: **3491603090** NYSID: **09839298P**  
Facility: **MDC** Housing Area: **9S**

## Subjective

Chief Complaint/Reason for Visit: **requests OTC and refills**  
History of Present Illness: **1) Triamcinilone reported as lost/misplaced and requesting refill - DC hydrocortisone, refill triamcinilone**  
**2) Eye doctor referral requested for L blurry vision x 2 weeks - referred.**  
**3) OTC dermavantage, bandaids - dermavantage ordered**

## Vital Signs History (previous visits review)

Last time vitals taken prior to this visit: **09/02/2020**  
BP: **124/76 (09/02/2020 12:55:17 PM)**  
Pulse: **89 (09/02/2020 12:55:17 PM)**  
Pulse Rhythm: **Regular (09/02/2020 12:55:17 PM)**  
RR: **15 (09/02/2020 12:55:17 PM)**  
Resp Quality: **Regular (09/02/2020 12:55:17 PM)**  
O2 Sat: **99 (09/02/2020 12:55:17 PM)**  
T: **99.3 (09/02/2020 12:55:17 PM)**

**Open Orders:** Medical Order - Chronic Care Follow-up [CHRONICFOLLOW]  
TPR [MHMIGRATION]  
MH Social Work Order - 30/90 Day Follow-Up [3090FOLLOW]  
Referral - Neurology [NEUROREF]  
On-Site Specialty Follow-Up - Podiatry [PODIAORDER]  
Referral - Bellevue, Dermatology [BELLEDERM]  
Offer Flu Vaccine [NURSFLU]  
MH Order - TPR and MH Clinician's Progress Note [TPR]  
Nursing Order - In-House Lab - Rapid Strep [RAPIDSTREP]

Signed By: Hai, R [REDACTED] at 11/10/2020 12:22:40 PM



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

## MED - Sick Call Visit

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

### FAST TRACK

Chief Complaint/Reason for Visit: **Pt is c/o loss of taste , and smell for 2 days .**

**Status of his dental appt .**

History of Present Illness: **Pt is here today c/o loss of taste , and smell for 2 days .**

**Pt denied fever , cough , sore throat .**

**Pt is requesting the status of his Dental appt .**

## Vital Signs Review

BP: **146/77** Pulse: **89** Pulse Rhythm: **Regular**

RR: **14** Resp Quality: **Unlabored**

O2 Sat: **99%** T: **98.4F**

### Open Orders:

Medical Order - Chronic Care Follow-up [CHRONICFOLLOW]

TPR [MHMIGRATION]

MH Social Work Order - 30/90 Day Follow-Up [3090FOLLOW]

Chem 7 Panel [0768-2]

Hepatic Function Panel [3422-3]

Referral - Bellevue, Dermatology [BELLEDERM]

Medical Order - Annual Physical [ANNUALPHY]

Hospital Transfer [INTHOSP]

NOVEL CORONAVIRUS COVID-19 NASOPHARYNX [TH68]

COVID19 IgG Antibody [2057204]

CDU Transfers [INTCDU]

Dental Order - Cleaning [DENTCLEAN]

Referral - Dental [DENTAL]

Referral - Neurology [NEUROREF]

MH Order - Mental Health Progress Note [MHPROGRESS]

MH Order - TPR and MH Clinician's Progress Note [TPR]

On-Site Specialty Follow-Up - Podiatry [PODIAORDER]

## INT - Step 1 - Vitals

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

Last height (inches): **72 (11/15/2019 5:46:00 PM)** Last Weight: **280 (11/15/2019 5:46:00 PM)**

BP Position: **Sitting**

BP: **124 / 76** mm Hg

Temperature: **99.3** FbaF

Temperature site: **Oral**

Pulse rate: **89** Pulse rhythm: **Regular**

RR: **15** Respiration Type: **Regular**

Pulse Ox: **99%** Room Air: **Yes**



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

## MED - Physical Examination

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

General

**General Appearance:** No Acute Distress, Well-developed, Well-Hydrated, Well-Nourished

**General Examination Notes:** Pt is AAO X 3 .

No SOB , No distress noted .

**HEENT: Head** Normocephalic

**HEENT: Eyes** PERRLA, EOMI

**HEENT: Ears** Tympanic membranes intact bilaterally, Ear canals unremarkable

**HEENT: Nose** Normal pink mucosa

**HEENT: Throat** Clear, No erythema or exudate

**HEENT: Oral Cavity** No lesions seen, Moist mucosa

**HEENT: Notes** Pt is c/o loss of taste and smell for 2 days .

Chest

**Inspection:** No lesions or scars

**Palpation:** No masses or lumps

Neck

**Neck:** Supple, No thyromegaly, No lymphadenopathy, No carotid bruit, No JVD, Normal ROM

**Thyroid:** Non-tender

Respiratory

**Respiratory Effort:** No respiratory distress

**Auscultation:** Clear to auscultation bilaterally

**Percussion:** No dullness to percussion

Cardiovascular

**Auscultation:** RRR, Normal S1 + S2

**Carotid Arteries:** No carotid bruit bilaterally

Gastrointestinal

**Abdomen:** Soft, Non-tender, Non-distended

**Liver & Spleen:** No hepatosplenomegaly

Musculoskeletal

**Gait & Station:** Normal

**Head & Neck:** No tenderness

**Back:** No CVAT bilaterally

**Joints:** FROM shoulder bilaterally, FROM hips bilaterally, FROM knees bilaterally

Neurological

**Cranial nerves:** Cranial Nerves II -> XII intact bilaterally

**Sensation:** Normal sensation V1 - V3 - bilaterally upper and lower extremities

**Strength:** 5/5 in all extremities

**Movement:** No tremor

Mental Status

**Judgement & Insight:** Good

**Orientation:** Oriented to person/place/time

**Mood & Affect:** Responds to questions appropriately, No suicidal ideation, No homicidal ideation, No auditory hallucinations, No visual hallucinations



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

## MED - Assessment & Plan

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

### **Allergy Review**

\* **CARROT (Critical)**

**FISH DERIVED (FLAVORING AGENT) (Critical)**

**Clindamycin (CLINDAMYCIN HCL CAPS) (Moderate)**

**Poultry (Moderate)**

**fish derived (Moderate)**

**lactose (Moderate)**

Allergies reviewed:

**YES**

### **Assessment:**

**Problem # 1:**

Taste sense altered (ICD-781.1) (ICD10-R43.9) - New Problem

1 - Pt is c/o loss of taste , smell . VS : WNL .

2 - Pt had COVID PCR positive on 04/2020 .

3 - Pt had repeat COVID 19 test : Negative on 08/15/2020 .

4 - Case D/W Urgicare Dr A. Litroff .

5 - No indication for medical isolation at this time .

6 - RTC on 09/08/2020 ; as needed .

**Problem # 2:**

Dental caries - unspecified

1 - Pt has appt with Dental on 09/03/2020 .

2 - MD advised the pt that DOC will notify him for his appt with Dental .

### **Summary:**

**Added new problem of Taste sense altered (ICD-781.1) (ICD10-R43.9) - Signed**

**Added new Referral order of Medical Order - Chronic Care Follow-up (CHRONICFOLLOW) - Signed**

Signed By: Desrosiers, J [REDACTED] at 9/2/2020 4:03:55 PM

NYC  
HEALTH+  
HOSPITALS

<b>PATIENT NAME:</b> PETER RODRIGUEZ	<b>FACILITY:</b> MDC
<b>NYSID:</b> 09839298P	<b>BOOKCASE#:</b> 3491603090
<b>DATE:</b> August 31, 2020	<b>TIME:</b> 11:38 PM

**PATIENT REFUSAL OF TREATMENT**

This is to certify that I am over the age of eighteen (18) years of age and I am refusing the following:

**Patient Refusing:** Injury Visit

I understand this refusal is against the advice of my health care practitioner. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure/treatment. I have been given time to ask questions about my condition and about my decision to refuse the procedure/treatment which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my refusal of treatment.

  
\_\_\_\_\_  
Signature of Patient

August 31, 2020

\_\_\_\_\_  
Date Signed

If CHS staff person's signature below, patient refused to present to clinic for informed consent discussion (Refused to Refuse):

**Signature of Person Documenting Patient's Refusal:** \_\_\_\_\_

**Date:** August 31, 2020

The above named patient refused the procedure/treatment, which is medically indicated, and necessary. I explained to the patient, the risks, consequences and dangers of refusing the procedure/treatment include but are not limited to the following:


**Discussed the following:** Risks & consequences addressed

I provided the above named patient with the opportunity to ask questions, I have answered the questions asked and it's my professional opinion that the patient understands what I have explained:

**Authorized Health Care Provider's Name:** Tatem PA, Christopher

**Authorized Health Care Provider's Signature:**  **Date:** August 31, 2020

**Health Care Staff (not patient's Health Care Provider) who witnessed the patient's voluntary refusal to sign:**

**Witness Print Name:** PA Flores - C 

**Witness Signature:** \_\_\_\_\_ **Date:** August 31, 2020

**An Interpreter was needed? If Yes, Interpreter's Name:**

**DEF 003844**



# Correctional Health Services

**Patient Name:**  
PETER RODRIGUEZ  
**NYSID:**  
09839298P

**Latest Book and Case#:**  
3491603090  
**Patient Facility:**  
MDC

## **SUBJECTIVE**

### **MED - Injury Report**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

#### **Initial Eval / Update**

Initial Evaluation? **Yes**

#### **CHS Injury Report**

DOC Injury Report available? **Yes**

DOC Injury Report #: **765**

Injury Date: **08/31/2020**

Injury HPI: **Pt denies injury/pain. Pt further refuses medical services. No signs of gross injury.**

Event Location: **Housing Area**

Cause: **DOC use of force/alleged attack by staff**

Verified Injury: **Denies injury (and no visible injury)**

Did the patient have a blow to the head? **No**

Is there a nasal injury? **No**

**Injury Determination: Were any of the following present? Refused and no visible injury**

## **OBJECTIVE**

### **NU - Vital Signs**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

#### **Current Vital Signs**

Refused vitals **Patient Refused Vital Signs**

## **ASSESSMENT**

### **MED - Assessment & Plan**

Patient: **PETER RODRIGUEZ** DOB: [REDACTED] Age: **29 Years Old**

Book & Case #: **3491603090** NYSID: **09839298P**

Facility: **MDC** Housing Area: **9S**

#### **Allergy Review**

\* **CARROT (Critical)**

**FISH DERIVED (FLAVORING AGENT) (Critical)**

**Clindamycin (CLINDAMYCIN HCL CAPS) (Moderate)**

**Poultry (Moderate)**

**fish derived (Moderate)**

**lactose (Moderate)**



# Correctional Health Services

**Patient Name:**

PETER RODRIGUEZ

**NYSID:**

09839298P

**Latest Book and Case#:**

3491603090

**Patient Facility:**

MDC

**Assessment:**

**Problem # 1:**

Injury - unspecified - initial encounter (ICD10-T14.90xA)

Pt denies injury/pain.

Pt further refuses medical services.

No signs of gross injury.

***PLAN***

**Summary:**

**ALL - Refusal of Treatment**

Patient: PETER RODRIGUEZ DOB: [REDACTED] Age: 29 Years Old

Book & Case #: 3491603090 NYSID: 09839298P

Facility: MDC Housing Area: 9S

**Refusal of Treatment - Location**

Date of Refusal: 08/31/2020

Location of Service: On-Site

**Refusal of Treatment**

Type of Service Refused: Medical

Specific Service Refused (Medical): Injury Visit

**Refusal of Treatment - Refuse to Sign?**

Did the patient refuse to sign the refusal form? Yes

**ALL - Refusal - Risks/Con/Capc**

Does the patient understand that this refusal is against the advice of the health care provider? Yes

What is the risk associated with refusing this service/intervention? Low

If Life-Threatening, see Capacity Policy and consider ER transfer for refusal at tertiary care center

Acknowledged

Did you explain to the patient, the risks, consequences and dangers of refusing the procedure/treatment? Yes

What did you explain to the patient regarding the risks, consequences and dangers of refusing the procedure/treatment (free text)? Risks & consequences addressed

Signed By: Tatem, C [REDACTED] at 8/31/2020 11:39:24 PM



**RODRIGUEZ, PETER**

NYSID: 09839298P BookCase: 3491603090  
Facility Code: BKDC Housing Area: 7B  
26 Y old Male, DOB [REDACTED]  
Account Number: 269405  
HOMELESS, NY, NY-11216

Insurance: Self Pay

Appointment Facility: Brooklyn Detention Center

04/14/2017

Sommar McDowald, PA

### Current Medications

#### Taking

- Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution Total Dose: 2 puffs Every 6 Hours, as needed, stop date 06/13/2017, KOP: No, Drug Source: Pharmacy
- Remeron 15 MG Tablet Total Dose: 15mg At Bedtime, stop date 04/18/2017, Drug Source: Pharmacy-Non Carry
- Vistaril 25 MG Capsule Total Dose: 25mg Every Morning, stop date 04/18/2017, Drug Source: Pharmacy-Non Carry
- Vistaril 50 MG Capsule Total Dose: 50mg At Bedtime, stop date 04/18/2017, Drug Source: Pharmacy-Non Carry

### Allergies

N.K.D.A.

### Reason for Appointment

- Pt states feeling SOB

### History of Present Illness

#### Notes::

26 y/o M presents to clinic for SOB since 1 week. Pt states he has difficulties exhaling with associated chest tightness, and states symptoms feels similar to asthma symptoms. Pt states he used albuterol pump approximately one hour prior to coming to clinic with no reported relief. Pt denies any strenuous activities prior to having symptoms, and further denies cough, palpitations, presyncopal episodes, dizziness, HA, back pain or any other medical complaint at this time.

#### VISIT COMPLEXITY SCALE:

##### NON-INTAKE ACUITY

Non-Intake Acuity Scale 2: *Complicated sick call (problem requiring diagnostic evaluation, documented history, physical exam, specified follow up) OR One chronic condition addressed with components specified in (3)*

### Vital Signs

BP			
Sitting:106/64	04/14/2017 03:11:32 PM	[REDACTED]	McDowald
Pulse			
93	04/14/2017 03:11:32 PM	[REDACTED]	McDowald
RR			
15	04/14/2017 03:11:32 PM	[REDACTED]	McDowald
Temp			
98.1	04/14/2017 03:11:32 PM	[REDACTED]	McDowald
Peak Flow			
300	04/14/2017 03:16:29 PM	[REDACTED]	McDowald
SaO2			

Patient: RODRIGUEZ, PETER DOB [REDACTED] Progress Note: [REDACTED] McDowald, PA 04/14/2017

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**DEF 006724**

100

04/14/2017 03:11:32  
PM

McDowald

**Examination****General Examination:**

GENERAL APPEARANCE: well-appearing, no acute distress.

HEART: RATE:-, regular, RHYTHM:-, regular, HEART SOUNDS:-, normal S1S2, MURMURS:-, none.

CHEST: SHAPE AND EXPANSION:-, normal.

LUNGS: clear to auscultation, no wheezes/rhonchi/rales, no accessory muscles used, patient able to speak full sentences with no difficulties..

ABDOMEN: soft, NT/ND, BS present, no masses palpated, no guarding or rigidity, no hepatosplenomegaly.

NEUROLOGIC EXAM: alert and oriented x 3, gait normal.

MENTAL STATUS: normal speech, good eye contact, No homicidal thinking, No suicidal thinking, no hallucinations.

**Assessments**

1. ASTHMA NOS - 493.90
2. Diagnosis deferred - 799.9

**Treatment****1. ASTHMA NOS**

Start Albuterol Sulfate Nebulization Solution, (2.5 MG/3ML) 0.083%, Total Dose: 2.5 ml, Inhalation, Stat, 0 days, KOP: No, Drug Source: RN/LPN DOT

Start Qvar Aerosol Solution, 40 MCG/ACT, Total Dose: 1 puff, Inhalation, Twice a day, 30 days, Drug Source: Pharmacy

Notes: Peak flow s/p albuterol neb tx is 350 with poor expiratory effort. SaO2 at 100 with no acute respiratory distress noted. Pt able to speak well with no accessory muscle use, no wheezing noted on PE. No concern for acute asthma exacerbation. Pt is medically stable to return to current housing area with medical asthma f/u in 2-3 days.

**2. Diagnosis deferred**

Notes: Of note, pt states it has been two years since the passing of his grandmother, and he feels anxious, denies SI, HI or hallucinations. Upon review of ECW, pt has MH visit scheduled with Mr Bush on 4/15/17. Will generate new MH referral to document patient's current complaint to be addressed with encounter with MH tomorrow.

Referral To:Mental Health BKDC Mental health

Reason:Of note, pt states it is two years since the lost of his grandmother and he feels anxious, denies SI, HI or hallucinations. Upon review of ECW, pt has MH visit scheduled with Mr Bush on 4/15/17. Please evaluate and advise

**Follow Up**

2 - 3 Days (Reason: asthma f/u)

Disposition: Return to Current Housing



Electronically signed by [REDACTED] McDowald , MS on  
04/14/2017 at 04:00 PM EDT

Sign off status: Completed

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Brooklyn Detention Center  
275 Atlantic Avenue  
Brooklyn, NY 11201  
Tel: 347-774-7000  
Fax: 347-774-8088

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Patient: RODRIGUEZ, PETER DOB [REDACTED] Progress Note: [REDACTED] McDowald, PA 04/14/2017

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**DEF 006726**



**RODRIGUEZ, PETER**

NYSID: 09839298P BookCase: 3491603090  
 Facility Code: AMKC Housing Area: MOD-10A  
 25 Y old Male, DOB [REDACTED]  
 Account Number: 269405  
 HOMELESS, NY, NY-11216

Insurance: Self Pay

Appointment Facility: Anna M. Kross Correctional Facility

03/22/2016

Appointment Provider: M [REDACTED] Kalam, MD

### Surgical History

Denies Past Surgical History

### Family History

Non-Contributory

### Social History

#### Intake social history:

#### Drug use

currently using drugs *Yes*

date last used *03/09/2016*

how often *daily*

how much spend on drugs (\$/day) *100*

what drugs do you use *cocaine, marijuana, benzodiazepines*

how do you use them *smoke, snort*

currently in methadone program *No*

Ever accidentally overdosed *No*

Ever used a needle to inject drugs *No*

### Allergies

N.K.D.A.

### Hospitalization/Major

### Diagnostic Procedure

Denies Past Hospitalization

### Reason for Appointment

1. New Admission Male

### History of Present Illness

#### New Intake:

#### Medical History

diabetes *No*

seizures *No*

chickenpox *yes*

#### Asthma History

asthma *Yes*

date diagnosed *2009*

needed steroids in last year *No*

best peak flow *> 500*

how often use rescue inhaler *rarely*

ever hospitalized *No*

ER visits in the last year *No*

#### HIV History

HIV/AIDS *no*

#### Mental Health History

Ever tried to hurt or kill yourself *no*

#### Expedited Intake:

#### Expedited Intake

Any current medical complaints? *remeron, risperdal*

History of head injury with LOC? *No*

Any other chronic disease? *none*

QFT/TB/PPD positive in the past? *No*

Any symptoms of tuberculosis (cough, etc.)? *No*

History of syphilis? *No*

Ever been hospitalized? *No*

Do you see a doctor regularly? *Yes*

See doctor for what? *check ups*

Do you have any history of mental health treatment? *Yes*

Are you having any Mental Health symptoms that are concerning to you? *No*

Are you having any thoughts of hurting or killing yourself? *No*

Country of birth? *USA*

History of alcohol or benzodiazepine abuse? *Yes*

Ever treated for withdrawal symptoms (seizures, tremors, etc.)?

*No*

Patient: RODRIGUEZ, PETER DOB [REDACTED] Progress Note: M [REDACTED] Kalam, MD 03/22/2016

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**DEF 007099**

Are you having withdrawal symptoms now? No

**Asthma Teaching:**

overexertion Exercise, Heat, Mold.

Medication compliance using albuterol daily.

Asthma control Daytime symptoms.

Inhaler technique Improper technique.

Educated on: Components of asthma- inflammatory and bronchospasm, Avoidance of triggers, Inhaler/Discus use, Controller medication use, Rescue Medication use, Signs and symptoms of acute attack, How to access clinic.

Asthma Action Plan New action plan.

**TEMPLATES:**

New Admission AMKC

**COMMUNITY MEDICATION FILL HISTORY:**

Did you check Community Medication Fill Database?

Did you check Community Medication Fill Database? Yes /

Community Medication Fill History Results (Copy/Paste from Database) /, Patient Not Found .

What medication are you currently taking? (As reported by patient) /Seroquel, Depakote.

**Community Pharmacy Check:**

INTAKE REMINDER **During Intake, work with patient to identify a community pharmacy where outpatient prescriptions may be sent upon discharge and document in eCW Patient Info > Additional Information > Pharmacies tab.**

**330 Suicide Prevention Form:**

330 Suicide Prevention Form

330 Suicide Prevention Form present? No /

330 Suicide Prevention Form reviewed by intake clinician? No /

**VISIT COMPLEXITY SCALE:**

INTAKE ACUITY

Intake Acuity Scale 3: 2 or 3 chronic conditions

**Vital Signs**

Ht		
6 ft	03/22/2016 01:46:51 PM	■■■■■ a Larsen
Wt		
279	03/22/2016 01:46:51 PM	■■■■■ Larsen
BMI		
37.84	03/22/2016 01:46:51 PM	■■■■■ a Larsen
BP		
122/71	03/22/2016 01:44:09 PM	■■■■■ a Larsen
Pulse		
	03/22/2016 01:44:09	

Patient: RODRIGUEZ, PETER DOB ■■■■■ Progress Note: Mohammad Kalam, MD 03/22/2016

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**DEF 007100**

<b>88</b>	PM	██████ Larsen
<b>RR</b>		
<b>16</b>	03/22/2016 01:44:09 PM	██████ Larsen
<b>Temp</b>		
<b>97.1</b>	03/22/2016 01:44:09 PM	██████ Larsen
<b>Peak Flow</b>		
<b>530</b>	03/22/2016 01:46:51 PM	██████ Larsen
<b>SaO2</b>		
<b>98</b>	03/22/2016 01:46:51 PM	██████ Larsen

**Past Orders**

Lab:Urine Drug Screen (Order Date - 03/22/2016) (Collection Date - 03/22/2016)

Benzos neg  
Cocaine neg  
Meth neg  
Opiates neg

Notes: Larsen, ██████ 3/22/2016 2:11:28 PM > .

**Physical Examination**General Appearance:

General Appearance: well-developed, pleasant.  
Hygiene: good.  
Ill-appearance: /.  
Mental Status: alert and oriented.  
Mood/Affect: pleasant.  
Speech: /.  
Eye contact: /, normal.  
Build: /.

HEENT:

Head: /, normocephalic, atraumatic, no scalp lesions.  
General /.  
Eyes: /, PERRLA.  
Fundi: /.  
Ears: /, normal.  
Nose: /, normal mucosa.  
Throat: /, no erythema or exudate.  
Oral cavity: /, no lesions seen, moist mucosa .

BACK:

General: Normal.  
Spine: /.  
ROM: /.

NECK:

General: normal.  
Cervical lymph nodes: /.  
Thyroid: /.

CHEST:

Shape and expansion: /, normal.

General normal.

DERMATOLOGY:

Skin: /.

Rash: /.

Tattoos: /.

General Normal.

BREASTS:

General normal, symmetric, no masses.

LUNGS:

Auscultation: CTA bilaterally, no wheezing/rhonchi/rales.

Airflow: /, normal air movement.

Rate: /.

Percussion: /.

Effort: /.

HEART:

Rate: regular.

Rhythm: /, regular.

Heart sounds: /, normal S1S2.

Murmurs: /, none.

PMI: /.

ABDOMEN:

General \_\_\_\_\_.

Auscultation: /, normal bowel sounds.

Palpation /, soft, nontender.

Hernia: /.

RECTUM/ANUS:

Digital Rectal Exam /, Not Indicated.

General \_\_\_\_\_.

Hemorrhoids: /.

Hemoccult: /.

GU - MALE:

Exam Not Done patient refused.

General \_\_\_\_\_.

External genitals: /.

Penis: /.

Scrotum: /.

Testicles: /.

Prostate: /.

EXTREMITIES:

General: Normal.

MUSCULOSKELETAL:

Joints Demonstration: apparent normal usage/shape .

SKIN:

General: unremarkable, warm.

LYMPHATICS:

Lymph Nodes /, No palpable adenopathy.

General \_\_\_\_\_.

Lymphedema: /.

NEUROLOGICAL:

General: Normal.

Cranial Nerves: /, CN's II-XII grossly intact.

Motor: /, normal strength bilaterally.  
Sensory: /, normal sensation.  
Reflexes: /.  
Plantars: /.  
Cerebellar: /.  
Gait: /, normal.  
Cognition: /.  
Involuntary Movements: /.  
Speech: /.  
Muscle Bulk: /.  
Tone: /.

**MENTAL STATUS EXAM:**

Orientation /, oriented to person, place and time.  
General Normal.  
Speech /, normal.  
Affect /, appropriate to mood.  
Mood /, euthymic.  
Psychomotor /, normal.  
Thought Process /, logical.  
Delusions /, denied.  
Hallucinations /, denied.  
Suicidal ideation /, denied.  
Homicidal ideation /, denied.

**Assessments**

1. ROUTINE MEDICAL EXAM - V70.0 (Primary)
2. ASTHMA NOS - 493.90, Well controlled.
3. Back pain - 724.5

**Treatment**

**1. ROUTINE MEDICAL EXAM**

LAB: Rapid HIV Test

LAB: Urine Drug Screen

LAB: RPR SEROLOGY

LAB: QUANTIFERON-TB IN-TUBE NY

LAB: Hepatitis C Rapid Screen (AMKC/RMSC ONLY)

LAB: CHLAMYDIA /GC, URINE

**2. ASTHMA NOS**

Start Albuterol Sulfate HFA Aerosol Solution, 108 (90 Base)  
MCG/ACT, Total Dose: 2 puffs, Inhalation, Every 6 Hours, as needed,  
90 days, Drug Source: Pharmacy  
Notes: Well controlled, use albuterol inhaler PRN.

**3. Back pain**

Start Naprosyn Tablet, 250 MG, Total Dose: 250 mg, Orally, Twice a  
Day, 3 days, Drug Source: Pharmacy

**Preventive Medicine**

Counseling:

Smoking .

Alcohol and drugs .

Diet .  
Exercise .  
Sexual practices .  
Testicular self exam .

**Follow Up**

4 Weeks (Reason: Asthma)

Notes: Pt was seen by M.H on 3/13/16, and that date, Pt came to facility. Pt was not seen by medical on that day. Disposition would be current housing.

**Appointment Provider: Mohammad Kalam, MD**



**Electronically signed by M [REDACTED] Kalam on 03/22/2016 at 03:47 PM EDT**

**Sign off status: Completed**

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**Anna M. Kross Correctional Facility  
18-18 Hazen Street  
East Elmhurst, NY 11370  
Tel: 718-546-3550  
Fax:**

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**Patient: RODRIGUEZ, PETER DOB [REDACTED] Progress Note: M [REDACTED] Kalam, MD 03/22/2016**

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**DEF 007104**